Region IX
Health Care Financing
Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Refer to: ORA-HPPO-MR

75 Hawthorne Street
San Francisco, CA 94105-3903

Appeal Rights for Medicare HMO Beneficiaries -- Effective 1/01/99

You should be aware that you and your HMO may disagree about what care is medically necessary. If your HMO refuses to pay for any service, or refuses to provide a Medicare covered service, and you believe it should pay for or provide the service, you may make an appeal to the HMO. Here are some examples of situations in which you have the right to appeal.

- Your doctor does not prescribe covered treatment or tests, refer you to a specialist, or does not admit you for hospital services you believe you need.

- Your HMO refuses to authorize or provide tests, treatments or referrals recommended by your primary care doctor.

- Your HMO or your doctor decides to discontinue or terminate services you are already receiving, such as home health care or physical therapy, or decides to discharge you from a nursing home.

- Your HMO will not pay your claims for emergency care or out of area urgent care you received from a non HMO provider.

Follow these steps when you disagree with your HMO's decision to deny a service or claim.

- If you have not already received a **written denial notice**, request one from the HMO. It should show the specific reason for the denial, and should include your appeal rights.

- If you believe that the HMO's determination is not correct, **request a reconsideration**. Normally, your HMO has 30 days to process a reconsideration of a service denial, and 60 days for a claim denial.

- You may file a request for reconsideration in writing with the HMO, with a Social Security office, or, if you are a railroad annuitant, with an office of the Railroad Retirement Board. If you file your request with a Social Security office or the Railroad Retirement Board, they will transfer your request to the HMO. **The request must be filed within 60 days of the notice of denial from the HMO.** You may mail your request or file it in person. You may also provide additional evidence to support your case in person or in writing.

- In some cases, you have the right to a **faster**, **72 hour appeal**. You can get a fast appeal if your health or ability to function could be seriously harmed by waiting 30 days for a standard reconsideration decision. The 72 hour process cannot be used to appeal a decision by the HMO denying payment for services that you have already received.

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- If you want a fast, 72 hour appeal, you may file an **oral** or a **written** request with your HMO. You should state that you want a 72 hour, fast appeal, or you believe that your health could be seriously harmed by waiting 30 days for a standard reconsideration decision. The addresses, phone and fax numbers to be used when requesting a 72 hour appeal are in your Evidence of Coverage (EOC), which should have been provided to you by your HMO.

  If you are in a hospital or nursing facility, you may ask for assistance in having your appeal sent to your HMO by use of a fax machine. You can mail your request; however, the 72 hour review time will not begin until your request is received. An extension of up to 14 working days is permitted for a 72 hour appeal if the extension of time benefits you; for example, if you need additional time to provide your HMO with additional information or your HMO needs to have additional diagnostic tests completed. If you ask for a 72 hour appeal, your HMO will decide if you will get one. If your HMO decides that your health would not be seriously harmed by waiting for a standard decision, they will process your appeal within 30 days. If a doctor, who is acting on your behalf, asks your HMO to give you a fast appeal or supports your request, your HMO must give it to you.

- If the HMO **cannot rule fully in your favor**, it must send the reconsideration request to the **Center for Health Dispute Resolution (CHDR)**. CHDR has a contract with the Health Care Financing Administration to review these types of disputes. In those cases that have been filed as 72 hour appeals, the Center will also send you its decision in writing within 72 hours of the receipt of your case from your HMO.

- If you **disagree** with the decision issued by the Center for Health Dispute Resolution and the amount in controversy is **$100 or more**, you may request **a Medicare hearing before an Administrative Law Judge (ALJ).**

- If you remain dissatisfied with the ALJ decision, the next level of appeal is a **review by the Departmental Appeals Board (DAB).**

- Lastly, if you are not satisfied with the outcome of the review by the Departmental Appeals Board, and the amount in controversy is **$1000 or more**, you may request a **review by the federal district court.**

If you decide to appeal and want help, you may have your doctor, a friend, a lawyer, or someone else help you. There are several groups that can help you. You may want to contact your local Area Agency on Aging or the Insurance Counseling and Assistance (ICA) program. These phone numbers can be found in your Evidence of Coverage (EOC).

NOTE:

These appeal rights apply only to claims and services which have been denied. If you have other complaints which involve issues such as waiting times, physician demeanor, quality of a service or facilities, you should follow your HMO's **grievance procedure.** This is explained in your HMO's EOC. If you do not have a copy of the EOC, ask your HMO to provide you with one.